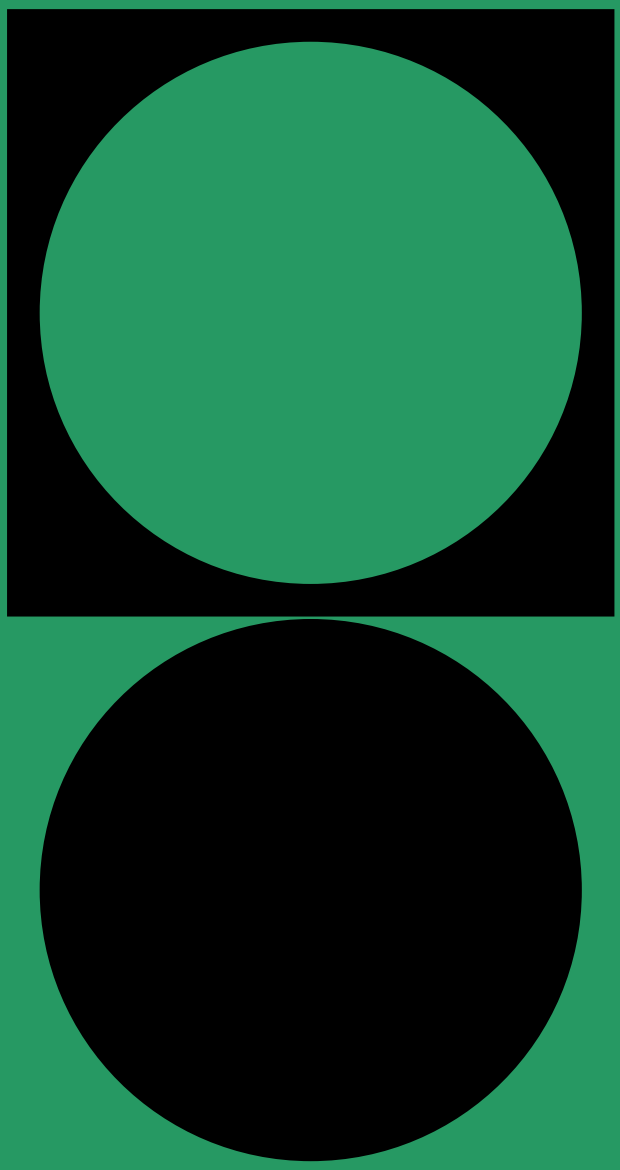
REGIONAL OVERVIEW: MIDDLE EAST AND NORTH AFRICA



THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION INTERNATIONAL

AUTHORS OF MIDDLE EAST AND NORTH AFRICA REGIONAL OVERVIEW: **Isabelle Salameh and Elie Aaraj**

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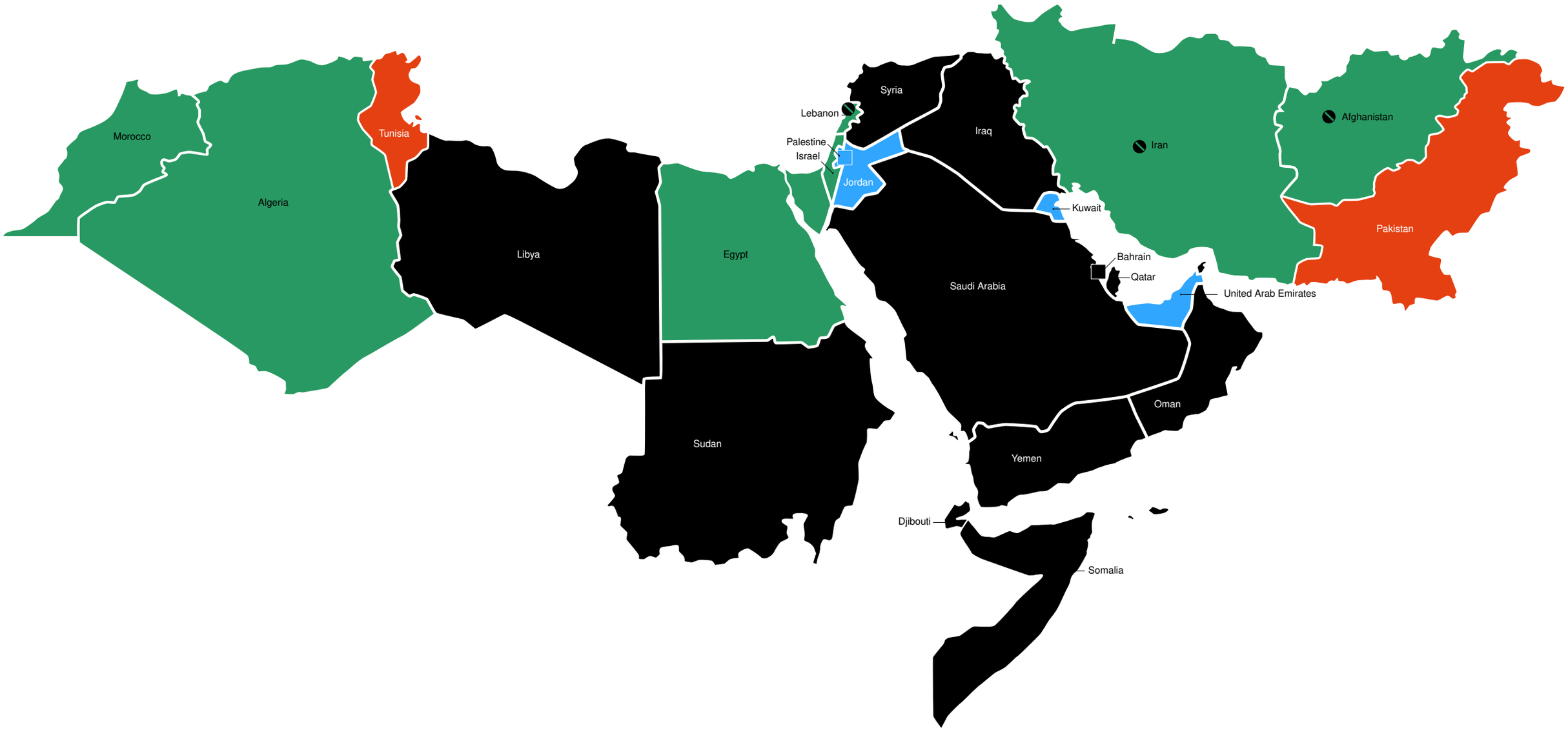
TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN ASIA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Afghanistan	57,207	1.41	23.08	2.77	✓ 8	✓ M	✓	×	×
Algeria	17,000	nd[f]	nd	nd	✓ 3	✓ M	nd	nd	×
Bahrain	5,100	3.89	3.89	nd	×	nd	×	×	×
Djibouti	nd	nd	nd	nd	×	nd	×	×	×
Egypt	96,230	3.73	nd	nd	✓	✓ M	×	×	×
Iraq	39,277	nd	nd	nd	×	×	×	×	×
Iran	138,250	8.3	36.8	3.04	✓	✓ M B	✓	×	×
Israel	nd	nd	nd	nd	✓	✓ M B	×	×	×
Jordan	10,488	0	nd	nd	×	✓	×	×	×
Kuwait	12,000	0.1	30.87	1.52	×	✓	×	×	×
Lebanon	9,000	0.05	23.59	1.07	✓ 1	✓ B	✓	×	×
Libya	6,677	87.1	94.2	4.5	×	×	×	×	×
Morocco	17,750	5.05	63.13	nd	✓ 3	✓ M	×	×	×
Oman	2,922	0.53	36.56	6.29	×	×	×	×	×
Pakistan	430,000	33.2	51.32	2.66	✓[g]	×	×	×	×
Palestine	5,000	0	41.48	6.15	×	✓ M B	×	×	×
Qatar	1,827	nd	nd	nd	×	×	×	×	×
Saudi Arabia	3,400	2.46	62.61	7.7	×	×	×	×	×
Somalia	392	nd	nd	nd	×	×	×	×	×
Sudan	986	nd	nd	nd	×	×	×	×	×
Syria	10,000	0	3.3	0.5	×	×	×	×	×
Tunisia	11,000	3.54	28.32	4.3	✓	×	×	×	×
United Arab Emirates	6,247	nd	nd	nd	×	✓	×	×	×
Yemen	844	nd	nd	nd	×	×	×	×	×

a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training and facilitates secondary distribution of naloxone between peers.
d At least on drug consumption room (also known as safe consumption sites among other names) operational in the country or territory.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data
g NSP in 45 district-level Continuum of Prevention and Care (CoPC+) sites and covers 62 districts through outreach.


Morocco
Algeria
Tunisia
Libya
Egypt
Sudan
Syria
Lebanon
Palestine
Israel
Jordan
Iraq
Iran
Afghanistan
Pakistan
Kuwait
Bahrain
Qatar
United Arab Emirates
Saudi Arabia
Oman
Yemen
Djibouti
Somalia
Both NSP and OAT available
OAT only
NSP only
Neither available
Not known
Peer-distribution of naloxone

NSP, OAT, DCRs AND SAFER SMOKING KITS

9 countries (38%) in the Middle East and North Africa provide **needle and syringe programmes** (no change from 2022)

11 countries (45%) in the Middle East and North Africa provide **opioid agonist therapy** (+4 from 2022, Egypt, Jordan, Kuwait, United Arab Emirates)

No country in the Middle East and North Africa provide **drug consumptions rooms** (no change from 2022)

No country in the Middle East and North Africa provide **safer smoking kits** (no change from 2022)

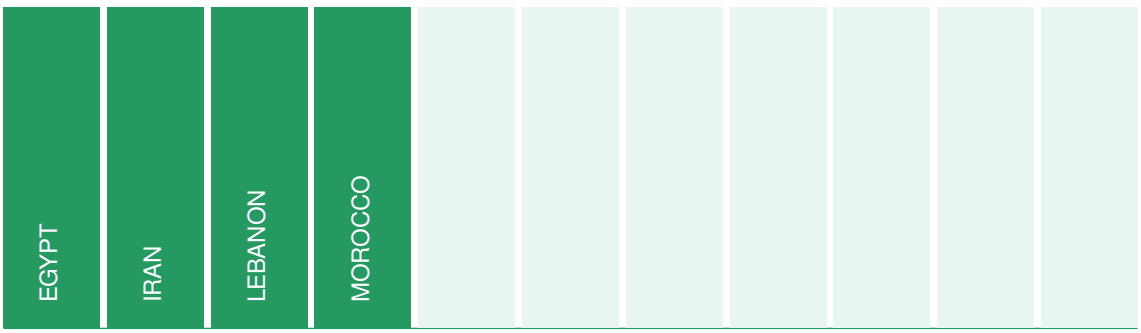
KEY ISSUE

BARRIERS TO HARM REDUCTION SERVICES

Socio-cultural barriers, such as stigma, discrimination, lack of public understanding, community resistance and religious factors, hinder the availability and accessibility of health services for people who use drugs.[1] These barriers are present not only in society but also within healthcare settings, affecting services related to needle and syringe programmes (NSP), opioid agonist therapy (OAT) and HIV.[2] In Egypt, a 2023 study found that healthcare staff in hospitals regularly stigmatise and discriminate against people who use drugs, which directly impacts access to services.[3]

Religiously-framed narratives in predominantly Islamic countries further restrict access to harm reduction services.[4,5] A systematic narrative review of studies on the experiences of people who use drugs in Muslim communities in Iran, Afghanistan, Egypt, Lebanon and the United Arab Emirates highlights the scarcity of research and data on drug use and harm reduction, stigma, and the psychosocial and organisational barriers that make it challenging for people who use drugs to access services.[6,7] In Algeria, religious barriers prevent people from seeking NSP services because using drugs is considered a major sin.[8] In Iran, unrealistic expectations from family and society, as well as stigma and the intertwining of treatment with ethical and religious principles, are identified as the most significant socio-cultural barriers to harm reduction and HIV treatment.[9] In Egypt, despite the significant scale-up of harm reduction services, some healthcare providers still perceive these services as culturally and religiously unacceptable.[10]

Although 11 countries mention harm reduction and people who use drugs in national policy documents, only 4 have adopted supportive policies in their National HIV Strategic Plans



Policymakers' unwillingness to prioritise and implement harm reduction measures, combined with centralised political power and 'top-down' health systems, significantly undermines harm reduction efforts. This results in poor implementation and sustainability, even when harm reduction is mentioned in national strategies.[11]

Although 11 countries mention harm reduction and people who use drugs in national policy documents, only 4 (Egypt, Iran, Lebanon and Morocco) have adopted supportive policies in their National HIV Strategic Plan.[12] As a result, the coverage of harm reduction services remains inadequate in the region.[13]

Punitive laws which criminalise the use of drugs further hinder the implementation of harm reduction services,[14] discourage people who use drugs from seeking services and increase levels of stigma and discrimination.[15] Strict punitive laws that criminalise the possession or use of drugs were documented in 14 countries in the region, while data from other countries is lacking.[16] In Iran, in 2023, the government executed 459 people for drug-related offences, a 79% increase from 2022 and the highest number in the country since 2015.[17,18,19] In Lebanon, around 3,000 people are arrested each year on charges related to substance use, depriving basic rights, such as treatment, support, education and employment, for those who are sentenced.[20]

These interlinked factors affect the resources allocated for harm reduction services, increase the stigmatisation and marginalisation of people who use drugs and discourage people who use drugs from seeking services.[21,22] Availability, accessibility and quality of harm reduction services, not only within communities but within prisons and other closed settings, are also impacted.[23,24] In Morocco, for instance, although OAT is available in prisons and other closed settings, it is reported to be largely inaccessible, and NSP and condoms are entirely unavailable as prison authorities believe these measures would incentivise drug use and sexual activity.[25] In Egypt, women who use drugs report being denied harm reduction services and rehabilitation treatment and also report humiliating experiences while in prison.[26]

As documented by the United Nations Development Programme (UNDP), key informants from Punjab in Pakistan reported that none of the province's 43 prisons, including 5 women's prisons, provide HIV services.[27] However, Nai Zindagi, a non-governmental organisation (NGO) in Pakistan, offers harm reduction services in 24 prisons (23 in Sindh and 1 in Khyber Pakhtunkhwa). Three of these are female prisons, and three are juvenile prisons. Harm reduction services provided are HIV testing, counselling on safer sex, linkages to antiretroviral treatment (ART) for HIV, adherence support, baseline investigation to initiate ART and linkages to hepatitis C treatment.

Due to budget cuts, UNAIDS was forced to close its Middle East and North Africa regional office. This has led to concerns about the continuity and sustainability of leadership and advocacy for HIV and the harm reduction response in the region.[28]

It has also made it challenging for community organisations that work on HIV, given that 70% of HIV infections in the region are among key populations,[a] and community-led NGOs provide the main frontline support for them.

a UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.

“ Punitive laws which criminalise the use of drugs further hinder the implementation of harm reduction strategies, discourage people who use drugs from seeking services and increase levels of stigma and discrimination. Strict punitive laws that criminalise the possession or use of drugs were documented in 14 countries in the region, while data from other countries is lacking. ”

KEY ISSUE

BARRIERS TO MEANINGFUL ENGAGEMENT OF KEY POPULATIONS

Representation and inclusion of affected communities are crucial for ensuring effective and equitable health responses. This is especially true in the Middle East and North Africa, where marginalised communities most affected by HIV are often excluded from decision-making processes.[29] People who use drugs face significant barriers to participating in the decision-making processes that affect them, leading to gaps in harm reduction services and policies that fail to appropriately address their needs. The barriers that prevent people who use drugs from participating in decision-making and programming relate to social and cultural factors, a lack of political will and commitment, stigma, discrimination and repressive and punitive legal frameworks.[30]

Despite this challenging backdrop, over the past two years, representation and engagement of key populations in the region has increased.[31] For instance, MENAROSA, a regional network established in 2010 for women living with HIV, and MENANPUD (the Middle East and North African Network for People who Use Drugs), an NGO established in 2007 to advocate for the rights of people who use drugs in the region, have participated and engaged in advocacy, campaigns, planning, research, mapping and programme implementation for people who use drugs. For the first time, in 2024, an important collaboration between the two organisations took place, with representatives developing a joint advocacy plan.[32,33] In mid-2024, they also began coordinating the MENA Learning Hub to focus on community engagement and learning in relation to the Global Fund's procedures and processes in the region.[34] The hub's first project will be to assess the learning needs of certain marginalised communities. This will focus on people living with HIV, women living with HIV, people who use drugs and people living with tuberculosis (TB) in all Global Fund eligible countries (Algeria, Djibouti, Egypt, Jordan, Morocco, Iraq, Lebanon, Libya, Palestine, the Syrian Arab Republic, Tunisia and Yemen).[35,36]

Despite the efforts of the last two years, it is still a significant challenge to include and represent people who use drugs in scaling up harm reduction services in the region.

The *Global State of Harm Reduction 2024* survey responses revealed varied involvement of people who use drugs in planning and implementation across different countries in the region for services related to NSP and OAT. In Egypt and Tunisia, NGOs reported no meaningful involvement of people who use drugs.[37,38] In Algeria and Afghanistan, responses were mixed, with some respondents unsure about the level of involvement and others affirming meaningful participation.[39,40,41] In Lebanon, the responses were inconsistent, with some stating involvement in planning only, implementation only, both, or none at all.[42] This highlights the lack of clarity regarding the engagement of people who use drugs in these programmes.

Civil society organisations have conducted various situation assessments and consultations on harm reduction in the region over the past few years. These assessments and engagements underscored the urgent need to involve and engage people who use drugs in the planning, implementation, monitoring and evaluation of advocacy initiatives, service delivery and policymaking. This involvement is essential to ensure effective, person-centred efforts and accountable decision making.

There have been several capacity building initiatives for key populations and organisations working in the harm reduction field, ensuring that all stakeholders have the essential skills and resources to meaningfully contribute to harm reduction efforts. For instance, in 2023, during a regional consultation, representatives from Libya and Yemen emphasised the need for meaningful engagement of people who use drugs in the creation of HIV National Strategic Plans and responses founded on human rights and gender equality. Representatives from Libya and Pakistan also advocated for a National Multi-Stakeholder Accountability Framework for people who use drugs to address the availability and accessibility of harm reduction services.[43] The need for community engagement in emergency situations was also highlighted in COVID-19 Emergency Preparedness Plans for Egypt, Jordan, Lebanon, Morocco, Tunisia and Yemen in order to ensure effective and timely crisis responses.[44]

The Global Fund Community, Rights and Gender (CRG) assessment on TB in Lebanon emphasised the importance of patient-centred care, community inclusion and patient rights. However, the *Lebanon National Strategic Plan to End Tuberculosis (2023-2030)* did not integrate community participation, revealing a gap in policy implementation.[45] The CRG assessment recommended promoting the involvement of people who use drugs and prioritising their unique needs so that key populations can be more effectively linked to essential TB services and support networks.

While there have been notable efforts to increase the representation and engagement of key populations, social, cultural and legal barriers continue to hinder meaningful participation, leading to gaps in harm reduction services and policymaking. Continued advocacy and targeted efforts are essential to ensure these communities are not only included in but are central to the development and execution of initiatives that directly affect their lives.

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